



U.S. Immigration
and Customs
Enforcement

December 18, 2017

MEMORANDUM FOR:

ICE

Atlanta Field Office

THROUGH:

ICE

Detention Monitoring Unit

FROM:

ICE

Detention Monitoring Unit

SUBJECT:

Request for Corrective Plan of Action

While conducting compliance monitoring duties at the Stewart Detention Center (SDC), Lumpkin, Georgia, the Detention Standards Compliance Officer (DSCO) and Detention Services Manager (DSM) noted a possible systemic non-compliant finding with the 2011 Performance-Based National Detention Standards, relating to Uses of Force, described below:

On May 6, 2017, an immediate use-of-force occurred in the sallyport of Unit #7-B, when a detainee refused to place his hands on the wall, in order to be placed in restraints. After repeated orders were not followed, the Shift Supervisor (Supervisor) employed an intermediate weapon (oleoresin-capsicum spray - "OC"), and then directed multiple staff members to restrain the passive-resistant subject.

On October 17, 2017, an immediate use-of-force occurred in the main corridor, when a detainee refused orders to return to his housing unit, and then refused to submit to restraints (handcuffs). The Shift Supervisor (involved in the preceding incident of May 6th) employed an intermediate weapon (OC), and then directed staff to restrain the passive-resistant subject.

On November 16, 2017, an immediate use-of-force occurred in Intake, involving a 61-year old, male detainee, who is wheelchair dependent. The detainee, who had just returned from a medical appointment, stood up from his wheelchair (Milestone Video), and picked up a spray bottle containing an unknown liquid. Video depicts the detainee opening the spray bottle, when a CoreCivic Supervisor successfully retrieves the bottle from the detainee's hand. The detainee is then observed to be emptyhanded (handheld audio-video) and stationary, for several seconds, before the Assistant Chief of Security (ACOS) delivers a burst of OC to the detainee's face. The detainee is

then placed in restraints; seated back into his wheelchair; and moved to an intake holding cell (shower) for decontamination. As staff lifted the detainee from his wheelchair, the detainee attempts to spit on the ACOS. Seconds later, the ACOS responds with a second burst of OC, striking the detainee in the back of the head.

The 2011 Performance-Based National Detention Standards (PBNDS), 2.15 *Use of Force and Restraints*, Section V. B. 3, states: "Staff shall use only that amount of force necessary and reasonable to gain control of a detainee." Based upon the detainee's demeanor (passive-resistant), in addition to the overwhelming number of staff present, the application of an intermediate weapon (OC) was not necessary, or reasonable, to gain control of the detainee.

Section V. E, states: "The following acts and techniques are generally prohibited, unless both necessary and reasonable in the circumstances: 1. Striking a detainee when grasping or pushing him/her would achieve the desired result." At no point during this incident did the Supervisor direct staff to physically-restrain the detainee. When his orders were not heeded, the Supervisor excessively elevated to the use of an intermediate weapon (OC).

Section II. 7, states: "Intermediate force devices shall be used only in circumstances prescribed herein." Section V. G. 3, states: "The facility administrator may authorize the use of intermediate force weapons if a detainee: a. is armed and/or barricaded; or b. cannot be approached without danger to self or other; and a delay in controlling the situation would seriously endanger the detainee or others, or would result in a major disturbance or serious property damage." None of the aforementioned conditions existed at the time of the Supervisor's employment of an intermediate weapon (OC).

These three incidents serve to establish a pattern of excessive uses-of-force by a Shift Supervisor, followed by excessive, uses-of-force by the ACOS. All of these incidents (standards violations) were reported to the Atlanta Field Office (Stewart), as well as the Joint Intake Center (JIC); however, effective corrective action has yet to result.

After review and consultation with the HQDMU, it has been determined that a written, Corrective, Plan of Action (POA) is required to address these identified deficiencies. The DMU is requesting that the POA provide details of the action to be implemented, to correct the aforementioned violations in Use of Force and Restraints, and prevent any reoccurrence in the future in order to remain compliant with the PBNDS 2011. Please provide a response no later than January 16, 2018.